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Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

CYNTHIA HARVEY, individually and on behalf of all others similarly situated,

Plaintiff,

v.

CENTENE MANAGEMENT COMPANY, LLC and COORDINATED CARE CORPORATION,

Defendants.

No. 2:18-CV-00012-SMJ

MOTION TO DISMISS FIRST AMENDED COMPLAINT

(Oral Argument Requested)

October 9, 2018, 11:00 a.m. in Spokane, WA

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Defendants Coordinated Care Corporation (Coordinated Care) and Centene Management Company (CMC), by undersigned counsel, hereby move to dismiss the First Amended Complaint (FAC) in this action pursuant to Rules 8(a) and 12(b)(6) of the Federal Rules of Civil Procedure.

PRELIMINARY STATEMENT

The FAC is a dramatically whittled-down version of Plaintiff's initial Complaint. As to the parties, Plaintiff has dropped Steven Milman (a Texas-based plaintiff), Centene Corporation (the Defendants' Missouri-based holding company), and Superior HealthPlan, Inc. (a Texas corporation) from the lawsuit. As to the claims, Plaintiff has given up on her causes of action under the Affordable Care Act and the Texas Deceptive Trade Practices Act. All that remains is a putative Washington-only class action based on state law claims of breach of contract and violation of the Washington Consumer Protection Act (CPA). The allegations themselves remain as thin as ever, still focused on an alleged inadequate provider network and the alleged failure to properly reimburse claims.

This slimmed-down, Washington-focused FAC makes apparent that Plaintiff is seeking to usurp the state regulator's job—to police network adequacy issues and challenge the rates paid for the insurance plans at issue. Those are matters that

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the Washington State Office of the Insurance Commissioner (OIC) is specifically charged with regulating. This Court should not allow Plaintiff to effect an end-run around the OIC's authority. It should likewise prevent Plaintiff from swapping CMC in for Centene Corporation. By voluntarily amending the Complaint to exclude Centene Corporation, Plaintiff essentially conceded that Coordinated Care's parent company is not a proper defendant. Neither is CMC. CMC is a Wisconsin corporation with its principal place of business in St. Louis, Missouri. It merely provides management and administrative services to Coordinated Care and other Centene subsidiaries. CMC is in no way Coordinated Care's alter ego, and so there is no basis for including CMC as a defendant.

The FAC should be dismissed for three reasons. *First*, the filed-rate-doctrine bars Plaintiff from bringing her claims, which, in essence, seek to challenge insurance rates already approved by the OIC. *Second*, the FAC fails to adequately allege a breach of contract. *Third*, the FAC fails to state a claim against CMC on an alter-ego theory.

BACKGROUND

On the eve of oral argument for the fully-briefed motion to dismiss the initial Complaint, Plaintiff sought leave to amend her Complaint to drop multiple parties and multiple claims. She filed the FAC shortly thereafter. The allegations still

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focus on Ms. Harvey's inability to access certain providers and the denial of certain claims. She now brings this action on behalf of "[a]ll persons in the state of Washington who were insured by Defendants' Ambetter insurance product which was purchased through an ACA [Health Insurance Exchange] from January 11, 2012 to the present." FAC ¶ 56.

ARGUMENT

Plaintiff alleges that, by maintaining an allegedly inadequate provider network and denying claims, Coordinated Care and CMC breached the insurance contracts between Coordinated Care and the putative class members, and violated the CPA. Among other things, on behalf of the class, Plaintiff seeks the "difference in value between the value of the policy as represented (the full premium prices paid) and the value of the policy as actually accepted and delivered . . . ." FAC ¶ 82.

The filed-rate doctrine precludes Plaintiff's claims because the claims challenge insurance rates that were filed with and approved by the OIC. Even if Plaintiff's claims were not precluded by the filed-rate doctrine, Plaintiff's breach-of-contract claim must be dismissed for being inadequately pled. Finally, Plaintiff cannot maintain either claim against CMC on an alter-ego theory, and CMC should be dismissed from the case.

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I. The Filed-Rate Doctrine Precludes Both of Plaintiff's Claims.

To adjudicate Plaintiff's damages claim under either her breach-of-contract or her CPA cause of action would require this Court to review and evaluate insurance rates that have already been approved by the OIC. The filed-rate doctrine bars precisely this kind of judicial interference with agency-regulated ratemaking. For that reason alone, Plaintiff's claims should be dismissed.

The OIC is charged with reviewing and approving health insurance premiums in Washington pursuant to a detailed framework of state laws and regulations. *McCarthy Finance, Inc. v. Premera*, 347 P.3d 872, 875 (Wash. 2015) (collecting relevant statutory and regulatory provisions). The state regulator protects consumers upfront from "ambiguous or misleading contracts and deceptive solicitations" and, after consumers sign up for a particular insurance policy, from "benefits [that] . . . are 'unreasonable in relation to the amount charged for the contract.'" *Id*. (citations omitted). To those ends, the OIC is vested with the authority to review health insurance plan contracts and approve or disapprove on a variety of grounds. Wash. Rev. Code § 48.44.020. One basis for disapproval is the failure to satisfy the minimum health insurance standards set forth in state regulations, *id*. § 48.44.020(2)(f), including the requirements for maintaining adequate provider networks. Wash. Admin. Code § 284-170-200. As

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part of the review process, the Commissioner requires insurers to submit detailed information concerning insurance rates and their ratemaking methodology. Wash. Rev. Code §§ 48.44.017(2) & 48.44.020(3). Rates and modifications of rates must go through the OIC review and approval process before taking effect. *Id*. § 48.44.020(3).

The filed-rate doctrine is designed to keep courts out of this agency-driven process. That doctrine is a "court-created rule to bar suits against regulated utilities involving allegations concerning the reasonableness of the filed rates. This doctrine provides, in essence, that any 'filed rate'—a rate filed with and approved by the governing regulatory agency—is per se reasonable." *McCarthy Finance, Inc.*, 347 P.3d at 875 (citation omitted). Courts fashioned this limitation on their own power with two purposes in mind: "(1) to preserve the agency's primary jurisdiction to determine the reasonableness of rates, and (2) to insure that regulated entities charge only those rates approved by the agency." *Id*. (citation omitted). To achieve those goals, courts will not reevaluate any filed and approved rates "because doing so would inappropriately usurp the agency's role." *Id*. at 873.

In *McCarthy Finance, Inc. v. Premera*, the Washington Supreme Court recently applied the filed-rate doctrine to a case involving health insurance. *See* 347 P.3d 872; *see also Heaphy v. State Farm Mut. Auto. Ins. Co*., No. C05

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5404RBL, 2006 WL 278556, at *2 (W.D. Wash. Feb. 2, 2006) (affirming that filed-rate doctrine applies to claims related to insurance premiums). Plaintiffs alleged that a group of insurers colluded and induced the plaintiffs to purchase policies under false pretenses and then charged them excessive and deceptive rates. *McCarthy Finance, Inc.*, 347 P.3d at 873–74. They sought compensation for the excessive premium payments. *Id*. at 874. The Washington Supreme Court affirmed dismissal of the plaintiffs' CPA claims based on the filed-rate doctrine. The key question was "whether the claims and damages related to agency-approved rates . . . would necessarily require courts to reevaluate agency-approved rates." *Id*. at 875. The court concluded that, to evaluate whether the premiums charged were excessive, it would need to "determine what health insurance premiums would have been reasonable for the Policyholders to pay as a baseline." *Id*. at 876. In other words, the "requested damages cause[d] [plaintiffs'] CPA claims to run squarely against the filed rate doctrine." *Id*.

That reasoning controls the outcome here: Plaintiff's CPA and breach-of-contract claims run headlong into the filed-rate doctrine. Just as in *McCarthy Finance*, Plaintiff's basic allegation is that she overpaid in premiums relative to the benefits she received, particularly with respect to the provider network covered by her policy. As to her CPA claim, Plaintiff seeks damages that capture the

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"difference in value between the value of the policy as represented (the full premium prices paid) and the value of the policy as actually accepted and delivered," which she also frames as "damages incurred as a result of having to pay for services that should have been covered by the insurance." FAC ¶ 82. As to her contract breach claim, Plaintiff seeks damages "consisting of all or part of the amount of the premiums . . . paid." *Id.* ¶ 70.

In framing her damages, Plaintiff effectively acknowledges that she received at least some benefits under her policy. To determine whether the benefits received rendered the premiums Plaintiff paid excessive, this Court would have to first assess a "reasonable . . . baseline" for what Plaintiff should have paid and then subtract that from the premiums charged by Coordinated Care. *McCarthy Finance, Inc.*, 347 P.3d at 876. That damages assessment would force the Court to reevaluate the insurance rates that the OIC has already reviewed and approved for Coordinated Care's policies in Washington. Therefore, the filed-rate doctrine bars Plaintiff from pursuing her claims, which would require this Court to second-guess the agency's determination. *See, e.g., Alpert v. Nationstar Mortgage LLC*, 243 F.Supp.3d 1176, 1183 (W.D. Wash. 2017) (applying the filed-rate doctrine to dismiss claim where plaintiff sought "difference between what he was charged and the reasonable cost of insurance"); *Hardy v. Claircom Comm'cns Grp. Inc.*, 937

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P.2d 1128, 495–96 (Wash. App. 1997) (dismissing claim because "court would necessarily have to consider the reasonableness of the rates charged").

Plaintiff may try to respond that she is challenging Defendants' conduct—the maintenance of inadequate provider networks and failure to reimburse claims—rather than the rates charged. For purposes of the filed-rate doctrine, however, those are two sides of the same coin. As the U.S. Supreme Court put it: "Rates . . . do not exist in isolation. They have meaning only when one knows the services to which they are attached. Any claim for excessive rates can be couched as a claim for inadequate services and vice versa." *American Tel. & Tel. Co. v. Cent. Office Tel., Inc.*, 524 U.S. 214, 223 (1998). Accordingly, "the filed-rate doctrine . . . bars suits challenging services, billing, or other practices when such challenges, if successful, would have the effect of changing the filed tariff." *Brown v. MCI, WorldCom Network Servs., Inc.*, 277 F.3d 1166, 1170 (9th Cir. 2002). Therefore, even if Plaintiff attempts to characterize her claims as focused on the insurance benefits at issue, she is still essentially alleging that the premiums she paid were too high in light of the benefits provided. This Court should reject Plaintiff's challenge to rates blessed by the OIC and dismiss Plaintiff's breach-of-contract and CPA claims as barred by the filed-rate doctrine.

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II. The FAC Fails To Adequately Plead Breach of Contract.

If Plaintiff's breach-of-contract claim were to survive the filed-rate doctrine, it still would fail on its own terms. Despite filing an amended complaint, Plaintiff has made no attempt to improve her deficient breach-of-contract claim. "In order to establish a breach of contract claim, the plaintiff must demonstrate proof of four elements: duty, breach, causation, and damages." *Burlington Insurance Co. v. Blind Squirrel*, LLC, 228 F.Supp.3d 1160 (E.D. Wash. 2017) (citation omitted). To survive a motion to dismiss, Plaintiff's claims "must contain sufficient allegations of underlying facts to give fair notice and to enable the opposing party to defend itself effectively." *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). Put slightly differently, the complaint's allegations must "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests." *Pickern v. Pier 1 Imps. (U.S.), Inc.*, 457 F.3d 963, 968 (9th Cir. 2006) (internal quotation marks omitted). Here, the allegations fail under these standards.

The Complaint plucks from the insurance contract some broad language delineating members' rights. FAC ¶ 66. The Complaint also lays out a scattering of instances in which Ms. Harvey was dissatisfied with her insurance coverage, as well as conclusory statements alleging that Defendants failed to maintain an adequate network. *Id*. ¶¶ 51–52. Taking that tack, any policyholder could

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transform small-scale grievances into a federal case of breach of contract. This approach gives Defendants no notice of *how* the alleged conduct breached the cited contractual provisions or *how* Defendants fell short of any obligations.

Plaintiff's allegation of damages is similarly deficient. Plaintiff describes her monetary loss and that of the purported class as "consisting of all or part of the amount of the premiums they paid as well as amounts they paid pursuant to improper billings by Defendants and expenses incurred in seeking or obtaining medical services." FAC ¶ 70. This vague approach amounts to saying that some undefined portion of what Plaintiff paid Coordinated Care represents her damages. Moreover, Plaintiff acknowledges that "[i]n many cases" she successfully utilized the appeals process built into the insurance contract to resolve her disputes with Coordinated Care, *id*. ¶ 53, adding further uncertainty to the allegations (including how Plaintiffs' allegations could amount to a breach of contract). Such an undefined claim provides no notice of what compensation Plaintiff is seeking or what specifically was breached, making it impossible for Defendants to respond. *See Adolf Jewelers, Inc. v. Jewelers Mut. Ins. Co.*, No. 3:08-CV-233, 2008 WL 2857191, at *4 (E.D. Va. July 21, 2008) ("[A]llegations that [plaintiff] (1) incurred unnecessary and considerable costs and other damages, (2) was inconvenienced, and (3) lost time do not give [defendant insurance company] fair notice of the

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grounds for [plaintiff's] claim." (internal quotation marks omitted)). Despite being presented a second time, the breach-of-contract claim remains facially inadequate and should be dismissed.

III. Plaintiff Fails To State a Claim Against CMC Under an Alter Ego Theory.

As an apparent admission that her alter ego theory against Centene Corporation was unworkable, Plaintiff dropped it as a defendant. But Plaintiff has added CMC as a defendant and now advances an even more tenuous alter ego theory—that this Court should pierce the veils of both Coordinated Care *and* CMC through their connection with Centene Corporation, and hold CMC liable for Coordinated Care's alleged wrongdoing.

This new alter ego theory—the sole discernible reason for including CMC as a defendant—fails like the first one. Plaintiff again ignores a foundational requirement of the alter ego doctrine—that the corporate form must be respected unless it has been misused to commit a fraud or injustice. Plaintiff makes no allegations at all explaining how the relationship between Coordinated Care and CMC effects any fraud or injustice on Plaintiff. But even as to the other main requirement of the alter ego doctrine—the total domination and control of one corporation by another—Plaintiff's allegations fall short.

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A. Plaintiff Fails To Allege Fraud or Injustice.

Whatever the relationship between two related corporate entities, veil-piercing is not appropriate unless it is required to avoid a fraud or injustice on the plaintiff. *See, e.g.*, *Meisel v. M & N Modern Hydraulic Press Co.*, 645 P.2d 689, 692 (Wash. 1982) (en banc) (recognizing that veil-piercing is appropriate only where it is "necessary and required to prevent unjustified loss to the injured party" (internal quotation marks and citation omitted)); *Massey v. Conseco Servs., L.L.C.*, 879 N.E.2d 605, 609 (Ind. App. 2008) (requiring that plaintiff show that "the misuse of the corporate form would constitute a fraud or promote injustice" (internal quotation marks and citation omitted)); *Consumer's Co-op v. Olsen*, 419 N.W.2d 211, 214 (Wis. 1988) (requiring plaintiff to show that "applying the corporate fiction would accomplish some fraudulent purpose, operate as a constructive fraud, or defeat some strong equitable claim" (internal quotation marks and citation omitted)).[1]

[1] Because Plaintiff seeks to disregard the corporate separateness of both Coordinated Care (an Indiana corporation) and CMC (a Wisconsin corporation), Indiana and Wisconsin law likely apply. *See* Restatement (Second) of Conflict of Laws § 307 (law of "state of incorporation" applies to questions of shareholder

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The FAC lacks any allegations that suggest this prong of the alter ego inquiry is met. The sole factual basis of Plaintiff's alter ego case is a one-paragraph cut-and-paste from a financial statement, which says that Coordinated Care contracts with CMC for the provision of various "management services." FAC ¶ 2. From that point forward, Plaintiff proceeds to ignore any distinction between the Coordinated Care and CMC. *See id.* (stating that the term "Centene" would be used to "refer to the joint activities of Centene Management Company, LLC and Coordinated Care").

Even if such a management services agreement were improper (as is shown below, *see infra* p. 15, it is not), Plaintiff fails to suggest any reason why that arrangement is fraudulent or unjust as to her. Notably absent from the FAC is any allegation that Coordinated Care is undercapitalized or unable financially to provide Plaintiff appropriate relief. In fact, Plaintiff's allegations suggest the opposite; she states that she has successfully used the appeal process provided for in her insurance contract to secure reimbursement from Coordinated Care. FAC ¶ 53. This is reason enough to dismiss Plaintiff's alter ego claim. If Coordinated Care can provide Plaintiff sufficient relief, then veil-piercing is clearly not

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liability). But the alter ego tests of Indiana, Wisconsin, and Washington are broadly similar, and Plaintiff's alter ego allegations would fail under each one.

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necessary. *See, e.g.*, *Poulos v. Naas Foods, Inc.*, 959 F.2d 69, 74 (7th Cir. 1992) (Wisconsin law) (recognizing that veil-piercing was not "required to avoid . . . possible fraud" because plaintiff could not allege "that the assets of [the subsidiary] would be insufficient to satisfy a judgment"); *Phillips v. USAA Cas. Ins. Co.*, No. 2:16-CV-0381-TOR, 2017 WL 26907, at *3 (E.D. Wash. Jan. 3, 2017) (Washington law) (declining to add defendant entity under veil-piercing theory because piercing was not "necessary to prevent an unjustified loss," as the subsidiary "is willing to pay the amount . . . owed").

Moreover, Plaintiff has not pled any causal connection between Defendants' corporate form and Plaintiff's alleged injury, nor has Plaintiff pled any misuse of the corporate form. *See, e.g.*, *Meisel*, 645 P.2d at 693 ("Intentional misconduct must be the cause of the harm that is avoided by disregard."); *CBR Event Decorators, Inc. v. Gates*, 962 N.E.2d 1276, 1282–83 (Ind. App. 2012) ("[T]he fraud or injustice alleged by a party seeking to pierce the corporate veil must be caused by, or result from, misuse of the corporate form."); *Consumer's Co-op*, 419 N.W.2d at 218 (misuse of corporate form "must proximately cause the injury or unjust loss complained of"). Plaintiff alleges that she was harmed because Coordinated Care did not appropriately reimburse her for various treatments. FAC

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¶¶ 51–53. These allegations have nothing at all to do with the relationship between Coordinated Care and CMC.

B. Plaintiff Fails To Allege Complete Domination.

Plaintiff does no better on the other prong of the alter ego test, which requires a showing that one company "complete[ly] dominat[ed]" the other. *Consumer's Co-op*, 419 N.W.2d at 217–18. The sole basis for Plaintiff's suggestion that CMC dominates Coordinated Care is that, under a "management services agreement," CMC provides Coordinated Care a number of management and administrative services. FAC ¶ 2. As was established in Centene Corporation's reply in support of its motion to dismiss, however, these arrangements are common and not indicative of a failure to respect corporate separateness. *See* Centene Reply at 5–6, ECF No. 33 (citing *In re Western States Wholesale Natural Gas Antitrust Litig.*, No. 03-cv-1431 *et al.*, 2009 WL 455658, at *11–*12 (D. Nev. Feb. 23, 2009); *Everitt v. Dover Downs Ent'mt Inc.*, No. 98-cv-6116, 1999 WL 374163, at *6 (E.D. Pa. June 9, 1999)). As the Court in *Everitt* noted, in a traditional holding company structure (like Centene's), it "makes economic sense" for "[c]ertain activities [to be] centralized." *Everitt*, 1999 WL 374163, at *6. That is all that Plaintiff has alleged that Defendants have done. Accordingly, her control allegations fall far short, and CMC should be dismissed.

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CONCLUSION

For the foregoing reasons, the Court should dismiss the FAC as to all Defendants.

Dated: August 1, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 1, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically sent a Notice of Electronic Filing to all parties in the case who are registered users of the CM/ECF system. The Notice of Electronic Filing for the foregoing specifically identifies recipients of electronic notice.

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